FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046201

Facility Name: Lemont Nursing & Rehab Center

Address: 12450 Walker Road (Number) Lemont (City) 60539 (Zip Code)

County: Cook

Telephone Number: (630) 243-0400 **Fax #** (630) 243-5063

IDPA ID Number: 38366376001

Date of Initial License for Current Owners: 02/01/03

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mike Kaplan **Telephone Number:** (847) 905-4042
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Mike Kaplan
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax #

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	158	Skilled (SNF)	158	57,670	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	158	TOTALS	158	57,670	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,564	14,138	12,514	52,216	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,564	14,138	12,514	52,216	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.54%

D. How many bed-hold days during this year were paid by the Department?
6 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 158 and days of care provided 12,357

Medicare Intermediary AdminaStar Federal -Springfield

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	305,137	31,659	15,662	352,458		352,458	8,774	361,232			1
2	Food Purchase		247,236		247,236		247,236	(25,005)	222,231			2
3	Housekeeping	160,125	33,103	15,146	208,374		208,374	(3,081)	205,293			3
4	Laundry	28,046	12,242		40,288		40,288	(35)	40,253			4
5	Heat and Other Utilities			166,210	166,210		166,210	2,064	168,274			5
6	Maintenance	100,830		122,371	223,201		223,201	9,633	232,834			6
7	Other (specify):*			393	393		393	2,124	2,517			7
8	**TOTAL General Services**	594,138	324,240	319,782	1,238,160		1,238,160	(5,526)	1,232,634			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	3,316,474	192,821	233,135	3,742,430		3,742,430	(15,285)	3,727,145			10
10a	Therapy		1,087	767,053	768,140		768,140	492	768,632			10a
11	Activities	138,457	31,843	2,144	172,444		172,444	(15)	172,429			11
12	Social Services	109,160		837	109,997		109,997		109,997			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*			1,160	1,160		1,160	(173)	987			15
16	**TOTAL Health Care and Programs**	3,564,091	225,751	1,043,329	4,833,171		4,833,171	(14,981)	4,818,190			16
	C. General Administration											
17	Administrative	131,222		304,282	435,504		435,504	(273,315)	162,189			17
18	Directors Fees											18
19	Professional Services			122,573	122,573		122,573	26,634	149,207			19
20	Dues, Fees, Subscriptions & Promotions			50,378	50,378		50,378	4,087	54,465			20
21	Clerical & General Office Expenses	183,890	25,983	51,266	261,139		261,139	164,530	425,669			21
22	Employee Benefits & Payroll Taxes			721,482	721,482		721,482	(359)	721,123			22
23	Inservice Training & Education			3,064	3,064		3,064		3,064			23
24	Travel and Seminar			719	719		719	4,526	5,245			24
25	Other Admin. Staff Transportation			2,212	2,212		2,212		2,212			25
26	Insurance-Prop.Liab.Malpractice			144,225	144,225		144,225	1,734	145,959			26
27	Other (specify):*			19	19		19	25,342	25,361			27
28	**TOTAL General Administration**	315,112	25,983	1,400,220	1,741,315		1,741,315	(46,821)	1,694,494			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,473,341	575,974	2,763,331	7,812,646		7,812,646	(67,328)	7,745,318			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lemont Nursing & Rehab Center #0046201 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			27,029	27,029		27,029	388,050	415,079			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35	35		35	367,379	367,414			32
33	Real Estate Taxes			247,143	247,143		247,143	1,697	248,840			33
34	Rent-Facility & Grounds			518,544	518,544		518,544	(506,186)	12,358			34
35	Rent-Equipment & Vehicles			23,921	23,921		23,921	(12,502)	11,419			35
36	Other (specify):*							77,877	77,877			36
37	**TOTAL Ownership**			816,672	816,672		816,672	316,315	1,132,987			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		484,809	4,255	489,064		489,064	(2,254)	486,810			39
40	Barber and Beauty Shops			9,907	9,907		9,907		9,907			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,505	86,505		86,505		86,505			42
43	Other (specify):* **Nonallowable Costs**			124,584	124,584		124,584	(124,584)				43
44	**TOTAL Special Cost Centers**		484,809	225,251	710,060		710,060	(126,838)	583,222			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,473,341	1,060,783	3,805,254	9,339,378		9,339,378	122,149	9,461,527			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See Schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,618)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,102)	30		9
10	Interest and Other Investment Income	(126,576)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,067)	43		18
19	Entertainment				19
20	Contributions	(1,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(75,849)	43		24
25	Fund Raising, Advertising and Promotional	(11,386)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(500)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch 5A	(37,610)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (263,708)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	385,857		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 385,857		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 122,149		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Lemont Nursing & Rehab Center
Provider #: 0046201
01/01/05 to 12/31/05 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
To offset Patient clothing Income	(15)	11
To disallow Sales Tax	(4,328)	43
To disallow Collection Expense	(728)	43
To disallow Radiology Expense	(21,404)	43
To disallow Laboratory Expense	(8,124)	43
To disallow Bldg. Co. Replacement Tax	(100)	43
To offset Misc. Income	(1,908)	21
To disallow Chamber Dues	(500)	20
To disallow Theft Loss	(189)	43
To disallow out of period Legal Fees	(314)	19
Total	(37,610)	

Lemont Nursing & Rehab Center

ID# 0046201

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. - Part A	$		1
2	Labs - Part A			2
3	X-Rays - Part A			3
4	Vending Machine Expense			4
5	Disallowed Non-Care Related Real Estate Tax			5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Lemont Nursing & Rehab Center **#** 0046201 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	4,069	0	0	(13,571)	0	0	(111)	0	0	(9,613)	1
2	Food Purchase	(6,618)	0	0	0	0	3,640	0	0	0	0	0	(2,978)	2
3	Housekeeping	0	0	0	0	0	0	0	0	(3,081)	0	0	(3,081)	3
4	Laundry	0	0	0	0	0	0	0	0	(35)	0	0	(35)	4
5	Heat and Other Utilities	0	0	2,064	0	0	0	0	0	0	0	0	2,064	5
6	Maintenance	0	0	9,595	0	0	38	0	0	0	0	0	9,633	6
7	Other (specify):*	0	0	1,191	0	365	568	0	0	0	0	0	2,124	7
8	**TOTAL General Services**	(6,618)	0	16,919	0	365	(9,325)	0	0	(3,227)	0	0	(1,886)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	(18,925)	0	0	(18,925)	10
10a	Therapy	0	0	493	0	0	0	0	0	(1)	0	0	492	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	67	0	(240)	0	0	0	0	0	0	(173)	15
16	**TOTAL Health Care and Programs**	0	0	560	0	(240)	0	0	0	(18,926)	0	0	(18,606)	16
	C. General Administration													
17	Administrative	0	0	(273,590)	0	0	275	0	0	0	0	0	(273,315)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,400	13,542	0	0	6	0	0	0	0	0	26,948	19
20	Fees, Subscriptions & Promotions	0	250	4,437	0	0	8	0	0	(108)	0	0	4,587	20
21	Clerical & General Office Expenses	0	0	165,811	0	0	632	0	0	(5)	0	0	166,438	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	(359)	0	0	(359)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	4,307	0	0	219	0	0	0	0	0	4,526	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,539	0	0	195	0	0	0	0	0	1,734	26
27	Other (specify):*	0	0	25,342	0	0	0	0	0	0	0	0	25,342	27
28	**TOTAL General Administration**	0	13,650	(58,612)	0	0	1,335	0	0	(472)	0	0	(44,099)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,618)	13,650	(41,133)	0	125	(7,990)	0	0	(22,625)	0	0	(64,591)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,102)	364,882	21,502	0	0	105	0	4,663	0	0	0	388,050	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(126,576)	488,364	0	3,590	0	0	0	1,649	0	0	0	367,027	32
33	Real Estate Taxes	0	0	0	1,697	0	352	0	0	0	0	0	2,049	33
34	Rent-Facility & Grounds	0	(514,224)	0	8,038	0	0	0	0	0	0	0	(506,186)	34
35	Rent-Equipment & Vehicles	0	0	0	1,448	0	20	0	(13,970)	0	0	0	(12,502)	35
36	Other (specify):*	0	77,877	0	0	0	0	0	0	0	0	0	77,877	36
37	**TOTAL Ownership**	(129,678)	416,899	21,502	14,773	0	477	0	(7,658)	0	0	0	316,315	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	2,760	0	0	(5,014)	0	0	(2,254)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(89,802)	100	0	0	0	0	0	0	(9)	0	0	(89,711)	43
44	**TOTAL Special Cost Centers**	(89,802)	100	0	0	0	2,760	0	0	(5,023)	0	0	(91,965)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(226,098)	430,649	(19,631)	14,773	125	(4,753)	0	(7,658)	(27,648)	0	0	159,759	45

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached List		See Attached List		Lemont Property, LLC	Evanston, IL	Building Co.
				See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	$	Lemont Property LLC	100.00%	$ 3,600	$ 3,600	1
2	V	19	Professional Services		Lemont Property LLC	100.00%	9,800	9,800	2
3	V	20	License and Fees		Lemont Property LLC	100.00%	250	250	3
4	V	30	Depreciation		Lemont Property LLC	100.00%	364,882	364,882	4
5	V	36	Amortization		Lemont Property LLC	100.00%	77,877	77,877	5
6	V	32	Interest Expense		Lemont Property LLC	100.00%	519,098	519,098	6
7	V	32	Interest Income		Lemont Property LLC	100.00%	(30,734)	(30,734)	7
8	V	33	Real Estate Tax	247,143	Lemont Property LLC	100.00%	247,143		8
9	V	34	Rent	514,224	Lemont Property LLC	100.00%		(514,224)	9
10	V	43	Illinois Replacement Tax				100	100	10
11	V								11
12	V								12
13	V								13
14	Total			$ 761,367			$ 1,192,016	$ * 430,649	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary - Salary	$	Care Centers, Inc.	100.00%	$ 3,741	$ 3,741	15
16	V	01	Dietary - Other		Care Centers, Inc.	100.00%	328	328	16
17	V	05	Utilities		Care Centers, Inc.	100.00%	2,064	2,064	17
18	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	4,550	4,550	18
19	V	06	Maintenance - Other		Care Centers, Inc.	100.00%	5,045	5,045	19
20	V	07	Employee Benefits - General Serv.		Care Centers, Inc.	100.00%	1,191	1,191	20
21	V	10	Nursing - Salary		Care Centers, Inc.	100.00%			21
22	V	10	Nursing - Other		Care Centers, Inc.	100.00%			22
23	V	10a	Therapy - Salary		Care Centers, Inc.	100.00%	493	493	23
24	V	10a	Therapy Other		Care Centers, Inc.	100.00%			24
25	V	15	Employee Benefits - Healthcare		Care Centers, Inc.	100.00%	67	67	25
26	V	17	Administrative - Salary		Care Centers, Inc.	100.00%	27,309	27,309	26
27	V	17	Administrative - Other	304,282	Care Centers, Inc.	100.00%	3,383	(300,899)	27
28	V	19	Professional Fees	5,400	Care Centers, Inc.	100.00%	18,942	13,542	28
29	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	4,437	4,437	29
30	V	21	Office & Clerical - Salary		Care Centers, Inc.	100.00%	149,321	149,321	30
31	V	21	Office & Clerical - Other		Care Centers, Inc.	100.00%	16,490	16,490	31
32	V	22	Employee Benefits		Care Centers, Inc.	100.00%			32
33	V	23	Inservice & Education		Care Centers, Inc.	100.00%			33
34	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	4,307	4,307	34
35	V	25	Other Admin. Staff Transportation		Care Centers, Inc.	100.00%			35
36	V	26	Insurance		Care Centers, Inc.	100.00%	1,539	1,539	36
37	V	27	Employee Benefits - Admin Serv.		Care Centers, Inc.	100.00%	25,342	25,342	37
38	V	30	Depreciation		Care Centers, Inc.	100.00%	21,502	21,502	38
39	Total			$ 309,682			$ 290,051	$ * (19,631)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	Care Centers, Inc.	100.00%	$ 3,590	$ 3,590	15
16	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,697	1,697	16
17	V	34	Rent-Building		Care Centers, Inc.	100.00%	8,038	8,038	17
18	V	35	Rent-Equipment & Auto		Care Centers, Inc.	100.00%	1,448	1,448	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 14,773	$ * 14,773	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		06	Maintenance Salary	$ 2,618	Care Centers, Inc.	100.00%	$ 2,618	$	15
16	V		07	Employee Benefits - Gen Service	393	Care Centers, Inc.	100.00%	758	365	16
17	V		10	Nursing Salary	7,735	Care Centers, Inc.	100.00%	7,735		17
18	V		10a	Therapy Salary	129	Care Centers, Inc.	100.00%	129		18
19	V		15	Employee Benefits - Healthcare	1,160	Care Centers, Inc.	100.00%	920	(240)	19
20	V		17	Administrative Salary		Care Centers, Inc.	100.00%			20
21	V		21	Office Salary		Care Centers, Inc.	100.00%			21
22	V		27	Employee Benefits - Gen. Admin.		Care Centers, Inc.	100.00%			22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 12,035			$ 12,160	$ * 125	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Care Center Health System	100.00%	$ 3,744	$ 3,744	15
16	V	01	Dietary Other	18,387	Care Center Health System	100.00%	1,072	(17,315)	16
17	V	02	Food	112	Care Center Health System	100.00%	3,752	3,640	17
18	V	06	Maintenance		Care Center Health System	100.00%	38	38	18
19	V	07	Employee Benefits - Gen Services		Care Center Health System	100.00%	568	568	19
20	V	10	Nursing Supplies		Care Center Health System	100.00%			20
21	V	17	Administrative		Care Center Health System	100.00%	275	275	21
22	V	19	Professional Fees		Care Center Health System	100.00%	6	6	22
23	V	20	Dues & Subscriptions		Care Center Health System	100.00%	8	8	23
24	V	21	Office & Clerical Salary		Care Center Health System	100.00%			24
25	V	21	Office & Clerical Other		Care Center Health System	100.00%	632	632	25
26	V	23	Inservice & Education		Care Center Health System	100.00%			26
27	V	24	Travel & Seminar		Care Center Health System	100.00%	219	219	27
28	V	26	Insurance		Care Center Health System	100.00%	195	195	28
29	V	30	Depreciation		Care Center Health System	100.00%	105	105	29
30	V	32	Interest Expense		Care Center Health System	100.00%			30
31	V	33	Real Estate Taxes		Care Center Health System	100.00%	352	352	31
32	V	34	Rent-Building		Care Center Health System	100.00%			32
33	V	35	Rent-Equipment & Auto		Care Center Health System	100.00%	20	20	33
34	V	39	Ancillary	4,876	Care Center Health System	100.00%	7,636	2,760	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 23,375			$ 18,622	$ * (4,753)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$ 157,326	CCS Employee Benefit Group	100.00%	$ 157,326	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 157,326			$ 157,326	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease LLC	100.00%	$ 4,663	$ 4,663	15
16	V	32	Interest Expense		Vent Lease LLC	100.00%	1,649	1,649	16
17	V	35	Rent - Equipment	13,970	Vent Lease LLC	100.00%		(13,970)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 13,970			$ 6,312	$ * (7,658)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 1,113	Xcel Medical Supply, LLC		$ 1,002	$ (111)	15
16	V	02	Food		Xcel Medical Supply, LLC				16
17	V	03	Housekeeping	31,084	Xcel Medical Supply, LLC		28,003	(3,081)	17
18	V	04	Laundry	353	Xcel Medical Supply, LLC		318	(35)	18
19	V	06	Repairs & Maintenance		Xcel Medical Supply, LLC				19
20	V	10	Nursing	190,888	Xcel Medical Supply, LLC		171,963	(18,925)	20
21	V	10a	Therapy	5	Xcel Medical Supply, LLC		4	(1)	21
22	V	11	Activities		Xcel Medical Supply, LLC				22
23	V	20	Dues, Fee, Subscriptions	1,093	Xcel Medical Supply, LLC		985	(108)	23
24	V	21	Clerical & General Office	48	Xcel Medical Supply, LLC		43	(5)	24
25	V	22	Employee Benefits	3,627	Xcel Medical Supply, LLC		3,268	(359)	25
26	V	39	Ancillary	50,574	Xcel Medical Supply, LLC		45,560	(5,014)	26
27	V	43	Other	88	Xcel Medical Supply, LLC		79	(9)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 278,873			$ 251,225	$ * (27,648)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Lemont Nursing & Rehab Center
Provider #: 0046201
01/01/05 to 12/31/05 Schedule 6

Partner Name	Ownership %
Nathan & Shirley Rothner Trust	22.00%
Eric Rothner	1.00%
William Rothner Accum. Trust	11.00%
Daniel Rothner Accum. Trust	11.00%
Rachel Rothner Accum. Trust	11.00%
Mellissa Rothner Accum. Trust	11.00%
Adam Vales Accum. Trust	11.00%
Kathryn Vales Accum. Trust	11.00%
Kimberly Richman Accum. Trust	11.00%
	100.00%

Lemont Nursing & Rehab Center
Provider #: **0046201**
01/01/05 **12/31/05** **Schedule 6A**

CARE CENTERS, INC.
SUMMARY OF NON-BUILDING RENTAL
RELATED ENTITIES
AS OF
December 31, 2005

	CARE CENTERS, INC.	CARE CENTERS HEALTH SYSTEMS	CCS EMPLOYEE BENEFITS GROUP	ROTHNER VENT LEASE LLC	HARBOR LIGHTS	
ILLINOIS HOMES						
Applewood Nursing & Rehabilitation Center	X	X	X			
Briar Place LTD.	X	X	X			
Chateau Village Nursing & Rehabilitation Center	X	X	X			
Colonial Hall Nursing & Rehabilitation Center	X	X	X			
Concord Extended Care	X	X	X			
Grasmere Place LLC	X		X			
International Village Nursing & Rehabilitation Center	X	X	X			
Lakewood Nursing & Rehabilitation Center	X	X	X			
Lemont Nursing & Rehabilitation Center	X	X	X			
Pavillion of Forest Park LLC	X	X	X			
Plum Grove Nursing & Rehabilitation Center	X	X	X			
Prairie Manor Health Care	X	X	X			
Rainbow Beach Nursing Center	X	X	X			
Ridgeland Nursing & Rehabilitation Center	X	X	X			
Rivershores Nursing & Rehabilitation Center	X	X	X			
Sheridan Shores Nursing & Rehabilitation Center	X	X	X			
Snow Valley Nursing & Rehabilitation Center	X	X	X			
Somerset Place LLC	X		X			
South Shores Nursing & Rehabilitation Center	X	X	X			
Tri-State Nursing & Rehabilitation Center	X	X	X			
Washington Heights Nursing & Rehabilitation Center	X	X	X			
Westshire Nursing & Rehabilitation Center	X	X	X			
Wheaton Care Center, LTD	X	X	X			
INDIANA HOMES						
Clark Nursing & Rehabilitation Center	X	X	X			
Dyer Nursing & Rehabilitation Center	X	X	X			
East Lake Nursing & Rehabilitation Center	X	X	X			
Lake County Nursing & Rehabilitation Center	X	X	X			
Northlake Nursing & Rehabilitation Center	X	X	X			
Sebos, Nursing & Rehabilitation Center	X	X	X			
Sheffield Manor	X		X			
Valparaiso Care & Rehabilitation Center	X	X	X			
OHIO HOMES						
McKinley Health Care Center	X	X	X			

Lemont Nursing & Rehab Center
Provider #: 0046201
01/01/05 12/31/05 **Schedule 6B**

RELATED NURSING HOMES
December 31, 2005

GROUP NAME	FACILITY NAME	CITY
CARE CENTERS, INC.	**ILLINOIS HOMES**	
	Applewood Nursing & Rehabilitation Center	MATTESON
	Briar Place LTD.	INDIAN HEAD
	Chateau Village Nursing & Rehabilitation Center	WILLOWBROOK
	Colonial Hall Nursing & Rehabilitation Center	PRINCETON
	Concord Extended Care	OAK LAWN
	Grasmere Place LLC	CHICAGO
	International Village Nursing & Rehabilitation Center	CHICAGO
	Lakewood Nursing & Rehabilitation Center	PLAINFIELD
	Lemont Nursing & Rehabilitation Center	LEMONT
	Pavillion of Forest Park LLC	FOREST PARK
	Plum Grove Nursing & Rehabilitation Center	PALATINE
	Prairie Manor Health Care	CHICAGO HEIGHTS
	Rainbow Beach Nursing Center	CHICAGO
	Ridgeland Nursing & Rehabilitation Center	PALOS HEIGHTS
	Rivershores Nursing & Rehabilation Center	MARSEILLES
	Sheridan Shores Nursing & Rehabilitation Center	CHICAGO
	Snow Valley Nursing & Rehabilitation Center	LISLE
	Somerset Place LLC	CHICAGO
	South Shores Nursing & Rehabilitation Center	CHICAGO
	Tri-State Nursing & Rehabilitation Center	Lansing
	Washington Heights Nursing & Rehabilitation Center	CHICAGO
	Westshire Nursing & Rehabilitation Center	CICERO
	Wheaton Care Center, LTD	WHEATON
	INDIANA HOMES	
	Clark Nursing & Rehabilitation Center	Gary
	Dyer Nursing & Rehabilitation Center	Dyer
	East Lake Nursing & Rehabilitation Center	Elkhardt
	Lake County Nursing & Rehabilitation Center	East Chicago
	Northlake Nursing & Rehabilitation Center	Merriville
	Sebos, Nursing & Rehabilitation Center	Holbart
	Sheffield Manor	Dyer
	Valparaiso Care & Rehabilitation Center	Valparaiso
	OHIO HOMES	
	McKinley Health Care Center	Canton

Lemont Nursing & Rehab Center
Provider #: 0046201
01/01/05 12/31/05 Schedule 6C

OTHER RELATED BUSINESS ENTITIES
AS OF
December 31, 2005

NAME		CITY	TYPE OF BUSINESS
CARE CENTERS, INC.		EVANSTON, IL	MANAGEMENT COMPANY
CARE CENTERS HEALTH SYSTEM		EVANSTON, IL	DIETARY & FOOD SUPPLEMENTS
HARBOR LIGHTS	*	GLEN ELLYN	HOSPICE
ROTHNER VENTS LLC		EVANSTON, IL	MEDICAL EQUIP RENTAL
2201 MAIN, LLC		EVANSTON, IL	BUILDING COMPANY

* - Page 6 & 8 Are not required for this entity since there was no payment from the Nursing Homes to the Related Entity

SEE THE ATTACHED SUMMARY FOR THE APPLICABILITY OF EACH RELATED BUSINESS ENTITY TO THE RELATED NURSING HOME

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.0000%	See Attached	1.11	2.77%	CCI -Salary	$ 2,664	17.-7	1
2	Adam Vales	Owner	Clerical	11.0000%	See Attached	1.02	2.55%	CCS -VEBA	1,260	21-7	2
3	Mark Steinberg	Relative	Administrative	0.0000%	See Attached	1.92	4.80%	CCI -Salary	2,566	17-7	3
4	Gale Rothner	Relative	Administrative	0.0000%	See Attached	1.22	3.05%	CCI -Salary	2,720	17-7	4
5	Kim Rudolph	Owner	Administrative	11.0000%	See Attached	0.94	2.35%	CCS -VEBA	761	21-7	5
6	Kim Rudolph	Owner	Administrative	11.0000%	See Attached			CCI -Salary	538	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,509		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 6020
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Salary	Patient Days	1,497,287	32	$ 107,276	$ 107,276	52,216	$ 3,741	1
2	1	Dietary Other	Patient Days	1,497,287	32	9,406		52,216	328	2
3	5	Utilities	Patient Days	1,497,287	32	59,188		52,216	2,064	3
4	6	Maintenance Salary	Patient Days	1,497,287	32	130,484	130,484	52,216	4,550	4
5	6	Maintenance Other	Patient Days	1,497,287	32	144,661		52,216	5,045	5
6	7	Employee Ben. - Gen. Services	Patient Days	1,497,287	32	34,158		52,216	1,191	6
7	10	Nursing Salary	Patient Days	1,497,287	32			52,216	0	7
8	10	Nursing Other	Patient Days	1,497,287	32			52,216	0	8
9	10a	Therapy Salary	Patient Days	1,497,287	32	14,139	14,139	52,216	493	9
10	10a	Therapy Other	Patient Days	1,497,287	32			52,216	0	10
11	15	Employee Ben. Healthcare	Patient Days	1,497,287	32	1,933		52,216	67	11
12	17	Administrative Salary	Patient Days	1,497,287	32	783,083	783,083	52,216	27,309	12
13	17	Administrative Other	Patient Days	1,497,287	32	97,000		52,216	3,383	13
14	19	Professional Fees	Patient Days	1,497,287	32	543,148		52,216	18,942	14
15	20	Dues & Subscriptions	Patient Days	1,497,287	32	127,217		52,216	4,437	15
16	21	Office & Clerical Salary	Patient Days	1,497,287	32	4,281,771	4,281,771	52,216	149,321	16
17	21	Office & Clerical Other	Patient Days	1,497,287	32	472,845		52,216	16,490	17
18	23	Inservice & Education	Patient Days	1,497,287	32			52,216	0	18
19	24	Travel & Seminar	Patient Days	1,497,287	32	123,511		52,216	4,307	19
20	25	Other Admin. Staff Transportation	Patient Days	1,497,287	32			52,216	0	20
21	26	Insurance	Patient Days	1,497,287	32	44,126		52,216	1,539	21
22	27	Employee Ben. - Gen. Admin	Patient Days	1,497,287	32	726,674		52,216	25,342	22
23	30	Depreciation	Patient Days	1,497,287	32	616,575		52,216	21,502	23
24	32	Interest	Patient Days	1,497,287	32	102,930		52,216	3,590	24
25	TOTALS					$ 8,420,125	$ 5,316,753		$ 293,641	25

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 6020
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	33	Real Estate Taxes	Patient Days	1,497,287	32	$ 48,662	$	52,216	$ 1,697	1
2	34	Rent- Building	Patient Days	1,497,287	32	230,488		52,216	8,038	2
3	35	Rent - Equipment & Auto	Patient Days	1,497,287	32	41,530		52,216	1,448	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 320,680	$		$ 11,183	25

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 6020
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance Salary	Direct Cost	2,618		$	$ 2,618		$ 2,618	1
2	7	Emp. Ben. - Gen Services	Direct Cost	758					758	2
3	10	Nursing Salary	Direct Cost	7,735			7,735		7,735	3
4	10a	Therapy Salary	Direct Cost	129			129		129	4
5	15	Emp. Ben. - Healthcare	Direct Cost	920					920	5
6	17	Administrative Salary	Direct Cost							6
7	21	Office Salary	Direct Cost							7
8	22	Employee Benefits	Direct Cost							8
9	27	Emp. Ben. - Gen Admin	Direct Cost							9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$ 10,482		$ 12,160	25

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Center Health System
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 6020
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Salary	Billable Income	928,452		$ 160,568	$ 160,568	21,647	$ 3,744	1
2	1	Dietary Other	Billable Income	928,452		46,000		21,647	1,072	2
3	2	Food	Billable Income	928,452		160,931		21,647	3,752	3
4	6	Maintenance	Billable Income	928,452		1,614		21,647	38	4
5	7	Employee Ben. - Gen. Services	Billable Income	928,452		24,382		21,647	568	5
6	17	Administrative	Billable Income	928,452		11,797		21,647	275	6
7	19	Professional Fees	Billable Income	928,452		262		21,647	6	7
8	20	Dues & Subscriptions	Billable Income	928,452		342		21,647	8	8
9	21	Office & Clerical Salaries	Billable Income	928,452				21,647		9
10	21	Office & Clerical Other	Billable Income	928,452		27,087		21,647	632	10
11	23	Inservices & Education	Billable Income	928,452				21,647		11
12	24	Travel & Seminar	Billable Income	928,452		9,381		21,647	219	12
13	25	Other Admin. Staff Transport.	Billable Income	928,452				21,647		13
14	26	Insurance	Billable Income	928,452		8,379		21,647	195	14
15	27	Employee Ben. - Gen. Admin	Billable Income	928,452				21,647		15
16	30	Depreciation	Billable Income	928,452		4,499		21,647	105	16
17	32	Interest	Billable Income	928,452		15,077		21,647	352	17
18	33	Real Estate Taxes	Billable Income	928,452				21,647		18
19	34	Rent- Building	Billable Income	928,452				21,647		19
20	35	Rent - Equipment & Auto	Billable Income	928,452		843		21,647	20	20
21	39	Ancillary Enteral Supplies	Billable Income	928,452		327,517		21,647	7,636	21
22										22
23										23
24										24
25	TOTALS					$ 798,679	$ 160,568		$ 18,622	25

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 6020
Phone Number: (847) 905-4000
Fax Number: (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	22	Employee Health Insurance	Direct Allocation	157,326					157,326	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 157,326	25

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 6020
Phone Number: (847) 905-4000
Fax Number: (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	593,410	29	$ 197,493	$	14,010	$ 4,663	1
2	32	Interest	Direct Billing	593,410	29	69,863		14,010	1,649	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 267,356	$		$ 6,312	25

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Xcel Medical Supply, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 6020
Phone Number: (847) 328-7600
Fax Number: (847) 3287615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct allocation			$	$		$ 1,002	1
2	2	Food	Direct allocation							2
3	3	Housekeeping	Direct allocation						28,003	3
4	4	Laundry	Direct allocation						318	4
5	6	Repair and Maintenance	Direct allocation							5
6	10	Nursing	Direct allocation						171,963	6
7	10a	Therapy	Direct allocation						4	7
8	11	Activities	Direct allocation							8
9	20	Dues, Fee, Subscriptions	Direct allocation						985	9
10	21	Clerical & General Office	Direct allocation						43	10
11	22	Employee Benefits	Direct allocation						3,268	11
12	39	Ancillary	Direct allocation						45,560	12
13	43	Other	Direct allocation						79	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 251,225	25

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage			$	$ 5,595,179			$ 24,278	1
2	Business Partners (Net)		x	Mortgage							465,283	2
3												3
4												4
5												5
	Working Capital											
6	Misc. Vendors										35	6
7	Genesis (Old Owners)							328,185			29,537	7
8	See Sch 9A										5,591	8
9	TOTAL Facility Related						$	$ 5,923,364			$ 524,724	9
	B. Non-Facility Related*											
10	Interest Income										(126,576)	10
11	Interest Income Bldg Co.										(30,734)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (157,310)	14
15	TOTALS (line 9+line14)						$	$ 5,923,364			$ 367,414	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** None **Line #** N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Care Centers										3,590	6
7	Allocated from Vent Lease										1,649	7
8	Allocated from CCHS										352	8
9	TOTAL Facility Related						$ 0	$ 0			$ 5,591	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 5,591	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Lemont Nursing & Rehab Center **#** 0046201 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 261,601	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2004	$ 248,144	2
3. Under or (over) accrual (line 2 minus line 1).		$ (13,457)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 260,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	**Home Office Allocation** 1,697	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 248,840	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	268,724	8
	2001	273,267	9
	2002	245,866	10
	2003	249,144	11
	2004	248,144	12

2005 accrual - 248144.28 x 1.05 =260600

Accrual Real Estate Tax Payable 260600 minus 2005 first Payment made in Dec. 2005 of124,073 = 136527

Allocated from Home Office - $ 1,697.04

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1600.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lemont Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Mike Kaplan

TELEPHONE (847) 905-4042 FAX #: (547) 905-3030

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-27-300-048-0000	Long Term Care Property	$ 248,144.28	$ 248,144.28
2.	See Attached Schedule	Long Term Care Property	$ 48,662.44	$ 1,697.04
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 296,806.72	$ 249,841.32

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs: Organization Cost, Loan Closing Cost, Settlement Charges, HUD Appraisal
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	823,094	2003	$ 823,094	1
2	2201 Main LLC			12,265	2
3	TOTALS			$ 835,359	3

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	115		2003		$ 4,683,421	$	Various	$ 263,253	$ 263,253	$ 894,682	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			2003	708,000		Various	63,405	63,405	176,176	9
10											10
11											11
12											12
13	2201 Main LLC Allocation Building			2002	16,902		20	433	433	1,427	13
14	2201 Main LLC Allocation Building Improvements			2002	13,962		20	698	698	2,443	14
15	2201 Main LLC Allocation Building Improvements			2003	16,454		20	823	823	2,057	15
16	2201 Main LLC Allocation Building Improvements			2005	818		20	18	18	18	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,439,557	$		$ 328,630	$ 328,630	$ 1,076,803	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,439,557	$		$ 328,630	$ 328,630	$ 1,076,803	1
2	Avary	2003	4,987	997	20	997		2,909	2
3	Cooler Repair	2003	522		20	26	26	76	3
4	Air Conditioner repair	2003	985	82	20	49	(33)	144	4
5	Sewer Rodding	2003	725		20	36	36	97	5
6	Sewer Maintenance	2003	640		20	32	32	85	6
7	Floor Title Replacement	2003	508	51	20	25	(26)	66	7
8	Lunchroom Door repair	2003	852		20	43	43	110	8
9	Parking Lot Lights	2003	1,290	129	20	65	(64)	167	9
10	Keypad Alarm	2003	547	78	20	78		195	10
11	Hot Water Repair	2003	950	79	20	48	(31)	115	11
12	Walk in Cooler - Compressor Repair	2003	1,450	97	20	73	(24)	175	12
13	Light Pole repairs	2003	2,959		20	148	148	358	13
14	Light Pole repairs	2003	1,090		20	55	55	132	14
15	Generator Repair	2003	859	86	20	43	(43)	100	15
16	Check Hot Water System	2003	937	78	20	47	(31)	109	16
17	State Required Backflow Test	2003	930	93	20	47	(46)	109	17
18	Insurance Proceeds	2003	(1,050)		20	(53)	(53)	(123)	18
19	Door Keypads and Sounder Install	2003	2,226	318	20	318		742	19
20	Toilet Bowls with Accessories	2003	631	63	20	32	(31)	71	20
21	Water Heater Repair	2003	504	42	20	25	(17)	57	21
22	Electrical Work	2003	2,545	255	20	127	(128)	286	22
23	Electrical Vestibule Doors	2003	7,060	706	20	353	(353)	794	23
24	Flash to Field or Wall Flashings	2003	800	80	20	40	(40)	90	24
25	Keypads and Dooesite Sounders	2003	6,679	891	20	334	(557)	751	25
26	Deposit on Above	2003	(2,226)		20	(111)	(111)	(250)	26
27	Speakman Valve Group	2003	710	71	20	35	(36)	77	27
28	Roton Hinge	2003	609	61	20	30	(31)	66	28
29	Rewire Feeds for Ceiling Lights	2003	630	63	20	32	(31)	68	29
30	Services on Fire Alarm Control Panel	2003	1,234	176	20	62	(114)	134	30
31	Install Softener System	2003	2,946	246	20	147	(99)	319	31
32	Adjust Rooms with Hot Water Problems	2003	930	77	20	46	(31)	101	32
33	Second Floor Dinning Room Heat Problems	2003	653	54	20	33	(21)	71	33
34	TOTAL (lines 1 thru 33)		$ 5,484,669	$ 4,873		$ 331,892	$ 327,019	$ 1,085,004	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,484,669	$ 4,873		$ 331,892	$ 327,019	$ 1,085,004	1
2	Replace Pipe	2003	633	127	20	32	(95)	69	2
3	Repair Four Mainonnorthdry System	2003	625	125	20	31	(94)	68	3
4	Fire Alarm Repairs	2003	966		20	48	48	137	4
5	Fire Alarm Pipe	2003	820		20	41	41	113	5
6	Fire Alarm Control Panel	2003	508		20	25	25	68	6
7	Ceiling Tile	2004	1,702	340	20	340		652	7
8	Sprinkler Replacement	2004	4,835	484	20	242	(242)	383	8
9	Ceiling Repair	2004	6,150	615	20	308	(307)	436	9
10	Water Heater	2004	4,347	362	20	362		724	10
11	HP Bronze Pump	2004	1,739	348	20	348		696	11
12	New Carpeting	2004	7,838	784	20	392	(392)	490	12
13	Painting	2004	6,500	650	20	325	(325)	379	13
14	Call Cords	2004	2,055	294	20	294		318	14
15	Repairs to Building Pipes	2005	7,375	676	20	338	(338)	338	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,530,762	$ 9,678		$ 335,018	$ 325,340	$ 1,089,875	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 370,787	$ 14,082	$ 74,725	$ 60,643	10 yrs	$ 228,956	71
72	Current Year Purchases	37,886	3,269	3,611	342	5 yrs	3,611	72
73	Fully Depreciated Assets	12,065					12,065	73
74								74
75	TOTALS	$ 420,738	$ 17,351	$ 78,336	$ 60,985		$ 244,632	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from CCI			$ 23,549	$	$ 1,725	$ 1,725	5	$ 17,833	76
77										77
78										78
79										79
80	TOTALS			$ 23,549	$	$ 1,725	$ 1,725		$ 17,833	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,810,408	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 27,029	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 415,079	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 388,050	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,352,340	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Lemont Nursing & Rehabilitation Center
Moveable Equipment Schedule
1/1/05-12/31/05
0046201

Line 28: Prior Years

Company Name	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Accumulated Straight Line Depreciation
Lemont Nursing & Rehab. Center LLC	82,878	14,082	14,270	188	27,151
Lemont Property LLC	199,083		38,224	38,224	141,747
2201 Main Street	3,909		556	556	1,970
Care Centers Inc.	84,917		16,907	16,907	58,088
Vent Lease			4,663	4,663	
Care Center Health System			105	105	
Total	370,787	14,082	74,725	60,643	228,956

Line 29: Current Year

Lemont Nursing & Rehab. Center LLC	25,640	3,269	3,269		3,269
Lemont Property LLC					
2201 Main Street	789		53	53	53
Care Centers Inc.	11,457		289	289	289
Vent Lease					
Care Center Health System					
Total	37,886	3,269	3,611	342	3,611

Line 30: Fully Depreciated

Lemont Nursing & Rehab. Center LLC	12,065				12,065
Lemont Property LLC					
2201 Main Street					
Care Centers Inc.					
Vent Lease					
Care Center Health System					
Total	12,065				12,065

Total (Should tie to page 13)

Lemont Nursing & Rehab. Center LLC	120,583	17,351	17,539	188	42,485
Lemont Property LLC	199,083		38,224	38,224	141,747
2201 Main Street	4,698		609	609	2,023
Care Centers Inc.	96,374		17,196	17,196	58,377
Vent Lease			4,663	4,663	
Care Center Health System			105	105	
Total	420,738	17,351	78,336	60,985	244,632

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Care Centers, Inc				8,038			5
6	Storage Site				4,320			6
7	TOTAL				$ 12,358 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 11,419 Description: $9,951 Copier, $20 CCHS, & $1,448 Care Centers, Inc
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a,C2	hrs	$		$ 69,264	$		$ 69,264	1
2	Licensed Speech and Language Development Therapist	L10a, C 3	hrs			28,198			28,198	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C 3	hrs			668,909			668,909	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				410,385		410,385	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Sch 16A					493	73,257		73,750	13
14	TOTAL			$		$ 766,864	$ 483,642		$ 1,250,506	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Lemont Nursing & Rehab Center
Provider #: 0046201
01/01/05 to 12/31/05 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Outside Practioner Cost	Supplies
Therapy And Rehab. Supplies	L 10A C 2			1,087
Ventilation Equipment	L 10A C 3			
Air Fluidized Beds	L 39 C 2			5,480
Oxygen	L 39 C 2			5,688
Other Services Medicare	L 39 C 3			10,193
Ambulance Services	L 39 C 3			80
Food Pump	L 39 C 2			7,636
Medical Supplies Chargeable	L 39 C 2			43,093
Respiratory Therapist CCI	L 10A C 1		493	
Total			493	73,257

Facility Name & ID Number Lemont Nursing & Rehab Center **#** 0046201 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 300	$ 300	1
2	Cash-Patient Deposits	19,685	19,685	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 175,000)	1,378,171	1,378,171	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	323,190	323,190	6
7	Other Prepaid Expenses	15,036	15,036	7
8	Accounts Receivable (owners or related parties)	275,388	275,388	8
9	Other(specify): See Sch 17A	2,646,290	2,646,290	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,658,060	$ 4,658,060	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		835,359	13
14	Buildings, at Historical Cost		4,731,557	14
15	Leasehold Improvements, at Historical Cost	83,172	799,205	15
16	Equipment, at Historical Cost	119,341	444,287	16
17	Accumulated Depreciation (book methods)	(60,820)	(1,352,340)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Financing Fee (Net)		167,229	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 141,693	$ 5,625,297	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,799,753	$ 10,283,357	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 648,433	$ 648,433	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,608	19,608	28
29	Short-Term Notes Payable		328,185	29
30	Accrued Salaries Payable	237,488	237,488	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,154	9,154	31
32	Accrued Real Estate Taxes(Sch.IX-B)	136,527	136,527	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	279,567	279,567	36
37	See Sch 17A	107,252	107,252	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,438,029	$ 1,766,214	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,595,179	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,595,179	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,438,029	$ 7,361,393	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,361,724	$ 2,921,964	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,799,753	$ 10,283,357	48

***(See instructions.)**

Lemont Nursing & Rehab Center
0046201
12/31/05

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

A. Current Assets

Other Current Assets (specify):	Operating	After Consolidation
Due From Employees	652	652
Note Payable LaSalle	2,645,638	2,645,638
Total Line 9 - Other Current Assets(specify):	**2,646,290**	**2,646,290**

B. Long Term Assets

Other Long Term Assets (specify):	Operating	After Consolidation
Total Line 23 - Other Long Term Assets Assets(spec	**0**	**0**

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Real Estate Escrow Deposit	16,360	16,360
Accrued Expenses	140,227	140,227
Due to Medicaid	116,422	116,422
Due to Third Party Insurance	6,558	6,558
Total Line 36 - Other Current Liabilities(specify):	**279,567**	**279,567**

Other Current Liabilities (specify):

Other Long Term Assets (specify):	Operating	After Consolidation
Due to Others		
Due to Other Related Parties		
Due to Prior Owners	107,252	107,252
Total Line 37 - Other Current Liabilities(specify):	**107,252**	**107,252**

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,462,818	1
2	Restatements (describe):		2
3	**FR&R Adjustments**		3
4	**Legal Fees**	3,316	4
5	**General Insurance**	4,283	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,470,417	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,260,174	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(368,867)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 891,307	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,361,724	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,229,599	1
2	Discounts and Allowances for all Levels	(3,873,965)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,355,634	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,423,936	6
7	Oxygen	3,172	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,427,108	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,257	13
14	Non-Patient Meals	6,618	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	413,051	17
18	Sale of Supplies to Non-Patients	15	18
19	Laboratory	127,811	19
20	Radiology and X-Ray	36,220	20
21	Other Medical Services	97,930	21
22	Laundry	3,424	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 688,326	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	126,576	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 126,576	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	1,908	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,908	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,599,552	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,238,160	31
32	Health Care	4,833,171	32
33	General Administration	1,741,315	33
	B. Capital Expense		
34	Ownership	816,672	34
	C. Ancillary Expense		
35	Special Cost Centers	623,555	35
36	Provider Participation Fee	86,505	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,339,378	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,260,174	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,260,174	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Lemont Nursing & Rehab Center
0046201
12/31/05

Schedule 19A

XVII. INCOME STATEMENT

Revenue

E. Other Revenue (specify):	Amount
Other Income	1,908
Total Line 28 - Other Revenue (specify):	**1,908**

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,972	2,167	$ 73,658	$ 33.99	1
2	Assistant Director of Nursing	1,920	2,160	62,295	28.84	2
3	Registered Nurses	24,391	27,122	824,664	30.41	3
4	Licensed Practical Nurses	25,301	27,509	670,269	24.37	4
5	CNAs & Orderlies	101,943	114,053	1,338,370	11.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,895	2,089	36,053	17.26	9
10	Activity Assistants	10,303	11,347	102,404	9.02	10
11	Social Service Workers	5,682	6,652	109,160	16.41	11
12	Dietician	1,075	1,214	17,097	14.08	12
13	Food Service Supervisor	3,059	3,329	54,687	16.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,572	6,280	73,830	11.76	15
16	Dishwashers	16,284	17,697	159,523	9.01	16
17	Maintenance Workers	5,607	5,857	100,830	17.22	17
18	Housekeepers	18,247	19,862	160,125	8.06	18
19	Laundry	3,459	3,709	28,046	7.56	19
20	Administrator	1,960	2,031	41,221	20.30	20
21	Assistant Administrator	1,412	1,858	90,001	48.44	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,664	12,213	183,890	15.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,836	3,125	37,964	12.15	31
32	Other Health Ca See Sch 20A	15,555	17,323	309,254	17.85	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	259,137	287,597	$ 4,473,341 *	$ 15.55	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	360	$ 15,662	L.1 C. 3	35
36	Medical Director	Monthly	39,000	L.9 C. 3	36
37	Medical Records Consultant	Monthly	624	L.10 C. 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,910	L.10 C. 3	39
40	Physical Therapy Consultant			L.10a C. 3	40
41	Occupational Therapy Consultant			L.10a C. 3	41
42	Respiratory Therapy Consultant			L.10a C. 3	42
43	Speech Therapy Consultant			L.10a C. 3	43
44	Activity Consultant	44	2,144	L.11 C. 3	44
45	Social Service Consultant	12	837	L.12 C. 3	45
46	Other(specify) See Sch 20B	356	10,482		46
47	Therapy Program Constultant	12	552	L.10a C. 3	47
48	Dental Consultant	Monthly	3,775	L.10 C. 3	48
49	TOTAL (lines 35 - 48)	784	$ 76,986		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,950	$ 143,398	L. 10 C. 3	50
51	Licensed Practical Nurses	1,559	62,455	L. 10 C. 3	51
52	Certified Nurse Assistants/Aides	506	11,238	L. 10 C. 3	52
53	TOTAL (lines 50 - 52)	5,015	$ 217,091		53

Lemont Nursing & Rehab Center
0046201
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Schedule 20A

XVIII. STAFFING AND SALARY COSTS
LINE 32 - Other (Health Care specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Rehab Nurse	1,570	1,896	$ 52,635	27.76
Rehab Aides	7,509	7,894	$ 89,703	11.36
Ward Clerk	1,413	1,736	$ 19,018	10.96
Care Plan Coord.	5,063	5,797	$ 147,898	25.51
Total Line 32 - Other	**15,555**	**17,323**	**$ 309,254**	**$ 17.85**

XVIII. STAFFING AND SALARY COSTS
LINE 33 - Other (specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
				#DIV/0!
				#DIV/0!
				#DIV/0!
Total Line 33 - Other	**0**	**0**	**$ -**	**#DIV/0!**

Lemont Nursing & Rehab Center
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Schedule 20B

XVIII. Consultant Services
LINE 46

	# of Hrs. Actually Worked	Reporting Period Total Consultant Costs	Schedule V Line & Column
Care Plan Coord - CCI	237	$ 7,735	L 10 C 3
Respiratory Therapist CCI	4	129	L 10a C 3
Maintenance - CCI	115	2,618	L 6 C 3
Total Line 46 - Other	**356**	**$ 10,482**	

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Franciso J Guajardo	Administrator	0	90,001
Jason H Gold	Asst. Administrator	0	41,221
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,222

B. Administrative - Other

Description	Amount
Home Office Services	$ 113,760
Home Office Bookkeeping Services	32,232
Management Fees	158,290
These Expenses were Elimanated in Col 7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 304,282
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Neal, Gerber & Eisenberg LLP	Legal	$ 74,648
Meyer Magence	Legal	350
Vedder Price	Legal	314
FR&R	Accounting	9,996
TBT Enterprises, Inc	Unemployment Consultant	1,091
Talx UMC Services	Unemployment Consultant	218
Care Center Inc.	Medicaid Application	5,400
SMS	Part B Billing	10,061
Rehab. Management System	PPS Consultant	900
ADP, INC	Payroll Services	7,242
Optimzer System	Medicare Software	125
See Sch 21A	Software Support	12,228
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 122,573

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 157,799
Unemployment Compensation Insurance	132,776
FICA Taxes	335,309
Employee Health Insurance	75,458
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	6,695
Other Misc. Employee Benefits	10,134
Holiday Expense	2,952
TOTAL (agree to Schedule V, line 22, col.8)	$ 721,123

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,658
Advertising: Employee Recruitment	41,644
Health Care Worker Background Check	
(Indicate # of checks performed 157)	3,319
Various Dues	285
Various Subscriptions	1,343
Various License	1,521
License from BLDG CO.	250
Allocated from Care Centers	4,437
Allocated From Care Center Health Sys	8
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 54,465

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	719
Allocation From Care Centers	4,307
Allocated From Care Center Health Sys	219
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,245

* Attach copy of IMRF notifications

**See instructions.

Lemont Nursing & Rehab Center
Provider #: 0046201
01/01/05 to 12/31/05 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Achieve Healthcare	Consultant on A/R Software	10,458
Ehealth Data Solutions	Billing Program System	1,770
Total		12,228

Total (agree to Schedule V, line 19, column 3)	122,573
Allocated from Management Company	18,942
Allocated from Care Center Health System	6
Allocated from Bldg. Co. - Legal	3,600
Allocated from Bldg. Co. - Other Professional Fees	9,800
To disallow Care Centers, Inc Medicaid Application Fee	(5,400)
To disallow Out of Period Legal Fees	(314)
Total (agree to Schedule V, line 19, column 8)	149,207

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **76,559** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **86,505**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,618**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	305,137	31,659	15,662	352,458	0	352,458	8,774	361,232
2. Food Purchase	0	247,236	0	247,236	0	247,236	(25,005)	222,231
3. Housekeeping	160,125	33,103	15,146	208,374	0	208,374	(3,081)	205,293
4. Laundry	28,046	12,242	0	40,288	0	40,288	(35)	40,253
5. Heat and Other Utilities	0	0	166,210	166,210	0	166,210	2,064	168,274
6. Maintenance	100,830	0	122,371	223,201	0	223,201	9,633	232,834
7. Other (specify)*	0	0	393	393	0	393	2,124	2,517
8. Total General Services	594,138	324,240	319,782	1,238,160	0	1,238,160	(5,526)	1,232,634
9. Medical Director	0	0	39,000	39,000	0	39,000	0	39,000
10. Nursing & Medical Records	3,316,474	192,821	233,135	3,742,430	0	3,742,430	(15,285)	3,727,145
10a. Therapy	0	1,087	767,053	768,140	0	768,140	492	768,632
11. Activities	138,457	31,843	2,144	172,444	0	172,444	(15)	172,429
12. Social Services	109,160	0	837	109,997	0	109,997	0	109,997
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	1,160	1,160	0	1,160	(173)	987
16. Total Health Care & Programs	3,564,091	225,751	1,043,329	4,833,171	0	4,833,171	(14,981)	4,818,190
17. Administrative	131,222	0	304,282	435,504	0	435,504	(273,315)	162,189
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	122,573	122,573	0	122,573	26,634	149,207
20. Fees, Subscriptions & Promotion	0	0	50,378	50,378	0	50,378	4,087	54,465
21. Clerical & General Office	183,890	25,983	51,266	261,139	0	261,139	164,530	425,669
22. Employee Benefits & Payroll	0	0	721,482	721,482	0	721,482	(359)	721,123
23. Inservice Training & Education	0	0	3,064	3,064	0	3,064	0	3,064
24. Travel and Seminar	0	0	719	719	0	719	4,526	5,245
25. Other Admin. Staff Trans	0	0	2,212	2,212	0	2,212	0	2,212
26. Insurance-Prop.Liab.Malpractice	0	0	144,225	144,225	0	144,225	1,734	145,959
27. Other (specify)*	0	0	19	19	0	19	25,342	25,361
28. Total General Adminis	315,112	25,983	1,400,220	1,741,315	0	1,741,315	(46,821)	1,694,494
29. Total General Administrative	4,473,341	575,974	2,763,331	7,812,646	0	7,812,646	(67,328)	7,745,318
30. Depreciation	0	0	27,029	27,029	0	27,029	388,050	415,079
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	35	35	0	35	367,379	367,414
33. Real Estate	0	0	247,143	247,143	0	247,143	1,697	248,840
34. Rent - Facility & Grounds	0	0	518,544	518,544	0	518,544	(506,186)	12,358
35. Rent - Equipment & Vehicles	0	0	23,921	23,921	0	23,921	(12,502)	11,419
36. Other (specify):*	0	0	0	0	0	0	77,877	77,877
37. Total Ownership	0	0	816,672	816,672	0	816,672	316,315	1,132,987
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	484,809	4,255	489,064	0	489,064	(2,254)	486,810
40. Barber and Beauty Shop	0	0	9,907	9,907	0	9,907	0	9,907
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	86,505	86,505	0	86,505	0	86,505
43. Other (specify):*	0	0	124,584	124,584	0	124,584	(124,584)	0
44. Total Special Cost Ce	0	484,809	225,251	710,060	0	710,060	(126,838)	583,222
45. Grand Total	4,473,341	1,060,783	3,805,254	9,339,378	0	9,339,378	122,149	9,461,527

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	300	300
2. Cash - Patient Deposits	19,685	19,685
3. Accounts & Notes Recievable	1,378,171	1,378,171
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	323,190	323,190
7. Other Prepaid Expenses	15,036	15,036
8. Accounts Receivable-Owner/Related Party	275,388	275,388
9. Other (specify):	2,646,290	2,646,290
10. Total current assets	4,658,060	4,658,060
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	835,359
14. Buildings, at Historical Cost	0	4,731,557
15. Leasehold Improvements, Historical Cost	83,172	799,205
16. Equipment, at Historical Cost	119,341	444,287
17. Accumulated Depreciation (book methods)	-60,820	-1,352,340
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	167,229
24. Total Long-Term Assets	141,693	5,625,297
25. Total Assets	4,799,753	10,283,357
CURRENT LIABILITIES		
26. Accounts Payable	648,433	648,433
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	19,608	19,608
29. Short-Term Notes Payable	0	328,185
30. Accrued Salaries Payable	237,488	237,488
31. Accrued Taxes Payable	9,154	9,154
32. Accrued Real Estate Taxes	136,527	136,527
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	279,567	279,567
37. Other Current Liabilities (specify):	107,252	107,252
38. Total Current Liabilities	1,438,029	1,766,214
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	5,595,179
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	5,595,179
46.Total Liabilities	1,438,029	7,361,393
47.Total Equity	3,361,724	2,921,964
48.Total Liabilities and Equity	4,799,753	10,283,357

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,229,599
2. Discounts and Allowances for all Levels	-3,873,965
Subtotal - Inpatient Care	6,355,634
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	3,423,936
7. Oxygen	3,172
Subtotal - Anciliary Revenue	3,427,108
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	3,257
14. Non-Patient Meals	6,618
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	413,051
18. Sale of Supplies to Non-Patients	15
19. Laboratory	127,811
20. Radiologyand X-Ray	36,220
21. Other Medical Services	97,930
22. Laundry	3,424
Subtotal - Other Operating Revenue	688,326
24. Contributions	0
25. Interest and Other Investments Income	126,576
Subtotal - Non-Operating Revenue	126,576
27. Other Revenue (specify):	1,908
28. Other Revenue (specify):	0
Subtotal - Other Revenue	1,908
30. Total Revenue	10,599,552
31. General Services	1,183,205
32. Health Care	4,854,258
33. General Administration	1,426,375
34. Ownership	790,234
35. Special Cost Centers	701,965
35. Provider Participation Fee	86,652
37. Other	0
40. Total Expenses	9,042,689
41. Income Before Income Taxes	1,556,863
42. Income Taxes	0
43. Net Income or Loss for the Year	1,556,863

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